Recommendation to Adopt a Severity-Adjusted Grouper

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
(410) 764-2605
Fax (410) 358-6217

June 2, 2004

This recommendation is ready for Commission action.

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INTRODUCTION

How to properly measure case mix has been the subject of much discussion in Maryland. The CMS DRG grouper has formed the foundation of the Commission's case mix adjustment, but a number of adjustments have been made to adapt this Medicare grouper for use in the State's all-payer system. The most important modifications have been to recognize services provided to populations that are not frequently represented among the Medicare population, such as neonates and HIV patients. Even with these adjustments, however, hospital representatives have argued that the variation within DRGs is too great and that case mix adjustment should be more refined to capture variation within DRGs.

On March 5, 2003, the Commission directed the staff to develop a severity-adjusted grouper for Maryland hospitals for this purpose. Of the options presented to the Commission, this "home-grown" option was chosen to provide a public domain product to hospitals and maintain the grouping methodology under the direct control of the Commission.

The staff proceeded with the development of an RFP to select a vendor to develop a severity-adjusted grouper. As the relationship between indirect medical education (IME) costs and case mix adjustment was discussed by hospital workgroups, however, hospital representatives noted that a long-term methodology could not be selected for the IME adjustment until a severity-adjusted grouper had been implemented. The MHA workgroup dealing with the IME issue urged the staff to reconsider the development of a Maryland grouper because of the time required for such an activity.

The Commission concurred with the industry's assessment, anticipating that the development of a "home-grown" grouper would require a minimum of a year's work plus an additional year for testing and analysis. At the February 18, 2004 Commission meeting, in response to these considerations, the Commission directed the staff to acquire a commercially available severity-adjusted grouper to use in the Commission's rate-setting system. The staff issued a bid board notice to solicit bids. At the meeting on May 5, 2004, the Commission rejected all bids to the first bid board notice (HSCRC-04-100) because the notice did not provide detailed evaluation criteria for selection. As the Commission directed, the staff issued another bid board notice (HSCRC-04-300) on May 13, 2004.

An evaluation committee composed of staff and hospital representatives reviewed the bids. On the basis of that review, the committee has selected 3M's bid for its APR-DRG grouper as the proposal most advantageous to the State based on the stated evaluation criteria:

- the product's ability to explain the variation in total charges across cases based on case mix weights developed under the Commission's current method for developing weights;
- the payment system incentives established under the product's grouping logic;
- the number of cells used to explain the variation in charges;

- openness of the product, in terms of understanding how the grouper assigns cases to specific case mix cells;
- frequency of product updates;
- direct costs of the product to the HSCRC;
- direct costs of the product to hospitals, payers, and related users;
- support services; and
- transition costs for the system.

The purpose of this document is to (1) propose the adoption of the APR-DRG grouper to measure case mix for all acute care hospitals in the State; and (2) to outline a transition plan to implement its use in HSCRC methodologies.

BACKGROUND

The MHA's ROC/ICC workgroup has worked on a variety of issues, including IME. The IME issue in particular has been the topic of numerous discussions of system equity across hospitals, and the workgroup has expressed a desire to design a long-term, stable approach to recognize IME in the system. The participants in that workgroup have observed that a substantial portion of the IME adjustment is not the teaching-related costs of residents, but a difference in the types of patients treated at teaching hospitals. The component of costs attributed to IME in the HSCRC regression methodology is in part unmeasured severity. The consensus in the workgroup has been that the Commission should adopt a severity-adjusted grouper as soon as possible to facilitate the development of a stable, long-term approach to adjust for indirect medical education.

The MHA workgroup has strongly supported the use of the APR-DRG grouper as the tool for measuring severity. The participants have noted that the development of a home-grown grouper would be both costly and time consuming. Additionally, there would be no real-world experience with the vendor's new product, and upon delivery, the home-grown grouper could meet considerable resistance from the industry. The APR-DRG grouper, on the other hand, has been developed over a number of years to incorporate severity adjustment based on clinical criteria, providing a logical basis for hospital administrations to coordinate care with the hospital's physicians. Given the certainty provided by the APR-DRG grouper versus the questions surrounding a home-grown case mix methodology, the workgroup has stated its strong support for the use of APR-DRGs. This endorsement was given in addition to the endorsement of both hospitals and payers in the case mix workgroup that advised the staff on the March 5, 2003 recommendation noted above.

ISSUES TO CONSIDER

Transition Issues

Because APR-DRGs make extensive use of diagnosis and procedure codes in a medical record, hospitals with complete coding are likely to do better under this grouper than those who have only attempted to maximize their coding under the current grouper. Part of the transition difficulty for moving to the use of APR-DRGs is the resource shift that

would occur simply due to coding differences within the industry. Selecting a future implementation date should minimize the effect to a degree; however, some hospital representatives have noted that coders are in short supply. Given the need to retrain existing coders and possibly expand the FTEs for coding records more completely, these representatives have been skeptical that a system-wide shift could be accomplished without major disruptions.

Coding experts have suggested that proper coding under APR-DRGs would require a 20-30% increase in coding resources in the State. This increase is not because the APR-DRG grouper requires different coding but because it makes more extensive use of the codes that should be documented already. In practice, however, hospitals may code sufficiently to optimize reimbursement under the modified CMS grouper currently in use and stop at that point. The APR-DRG grouper measures case mix as it relates to severity of illness. Because severity measurement in this grouper requires more detailed coding of cases, there is a financial incentive to more completely describe the care provided in the hospital.[1]

Audits

Because coding is crucial in measuring relative efficiency among hospitals as well as driving ongoing reimbursement during the year, the Commission will need a better understanding of hospitals' coding practices for any severity-adjusted grouper. Because APR-DRGs make extensive use of diagnosis and procedure codes to establish the severity level for an admission, understanding coding practices at each hospital becomes especially important in determining whether case mix growth is associated with real costs or with coding and documentation improvements at the hospital. Consequently, the staff is proposing (in a separate document) a policy for requiring each hospital to submit an annual case mix audit based on a random sample of its cases.

PROPOSAL

- *Adopt the APR-DRG grouper as the method for grouping cases when measuring case mix for all acute care hospitals in the State. The grouper would be used for constructing the case mix adjustment in all the Commission's methodologies.*

- *Establish FY 2005 as a base year to transition to the new grouper.* The Commission would expect hospitals to bring their coding up to speed in this base year. During that time, the current case mix methodology would remain in place, but a parallel ROC would be calculated to show hospital positions relative to the peer group with the APR-DRG grouper.

[1] More complete descriptions of care provide the opportunity to measure the quality of care within hospitals. Current applications of APR-DRGs as part of hospital performance measurement include the Maryland Health Care Commission's use of APR-DRGs for its Consumer Guide Publication, the Agency for Healthcare Research and Quality's (AHRQ) use of severity adjusted dis charge data for the development of Healthcare Cost and Utilization Project (HCUP) quality indicators, and the Texas Healthcare Information Council's adoption of APR-DRG's for use in clinical research studies (3M Website).

- *Establish an industry-wide audit procedure to monitor the quality of each hospital's coding and to examine whether reported changes in case mix result from coding improvements rather than service-mix changes.*

- *Establish limits to case mix growth each year.* In anticipation of coding improvements encouraged by the adoption of this severity-based grouper, case mix growth should be limited for the system. A number of options are available to adjust for case mix growth associated with coding optimization; for example, (1) A prospective adjustment could be made to the update factor to anticipate system-wide case mix optimization; (2) Governors could be placed on case mix growth to keep the impact specific to each hospital as opposed to a system wide adjustment. An example of such a method is the following: For case mix growth less than or equal to 1%, the hospital would receive its case mix growth as measured. Between 1% and 4%, the hospital would receive 50% of the growth above 1%. Beyond 4%, no case mix growth would be granted without demonstrated changes in hospital services or without a detailed review of the hospital's coding practices. The staff, in consultation with hospital and payer representatives, would propose the precise method for handling case mix growth prior to the implementation of the new grouper.

- *Adopt APR-DRGs in the Commission's rate-setting methodology for FY 2006 (beginning July 1, 2005).*

- *Provide no new funding for the transition costs associated with the move to this new grouper*. Costs for the grouper, associated products, staffing, training, and monitoring (through audits) would be financed from existing hospital revenues.

- *Establish a phase-in period for the transition to the use of this grouper to minimize disruptions to the rate-setting system as ROC positions are realigned with this methodology change*. The staff would recommend a phase-in plan before the beginning of FY 2006 (July 1, 2005).